

UTS TRAINING TIMES

Volume 7 Issue 4

FALL 2011

Inside this issue....

- The UTS First Steps Programmatic Training contract at ProKids has been extended through December 31, 2011. Courses for dates after December 31, 2011 are pending until the contract is finalized. In the meantime, email surveys were sent to all providers and provider agencies to solicit input for training. We look forward to your input!
- State First Steps staff regularly meets with Provider Agency representatives to provide program updates. Agencies should be sharing this information with all providers, including those with referral agreements. A summary of the September meeting is included.
- The flu season is approaching and it is now time to get your annual flu shot. You can
 educate yourself and the families you serve with the CDC handout, "The Flu: A Guide for
 Parents.
- The revised Progress Report forms are posted on the UTS website. All First Steps providers should be using the revised forms.
- Please take a minute to participate in the Autism Survey. See the back cover for additional information.

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INDIANA'S UNIFIED TRAINING SYSTEM

"Creating Learning Opportunities for Families and Providers Supporting Young Children"

First Steps Enrollment and Credential Training Requirements

Provider Level - New	Training for Enrollment	Training for Initial Credential
Service Coordinator (Intake and Ongoing) New to First Steps December 2007 and after	SC 101—SC Modules (self-study)	SC 102 within 3-6 months of employment date SC 103 within 6-9 months of employment date Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 15 points for initial credential
Direct Service Provider (new to First Steps December 2007 and after)	First Steps Orientation or DSP 101—Provider Orien- tation Course (self-study)	DSP 102 - 1/2 day within 3-6 months of enrollment (onsite) DSP 103 - 1/2 day within 6-12 months of enrollment (onsite) Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training—one course per credential year (self study or on-site) 10 or 15 points for initial credential
Provider Level - Credentialed	Training for Enrollment	Training for Annual Credential
Service Coordinator (Intake or Ongoing who has completed initial credential)	SC Orientation and Service Coordination Level 1 or SC 101 – SC Modules (self-study)	Quarterly (4) - Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential
Direct Service Provider (who has completed initial credential)	First Steps Orientation (on-site or self–study) or DSP 101 - Provider Orien- tation Course (self-study)	Quarterly (4) – Training Times Assessment (self-study) First Steps Core Training - one course per credential year (self study or on-site) 3 points for annual re-credential

Attention: New Providers and Service/Intake Coordinators

The Bureau of Child Development Services requires all providers and service coordinators to complete the quarterly *Training Times* assessment as part of your mandatory training requirements for credentialing.

New providers must establish an account on the UTS website (http://www.utsprokids.org) to register for UTS trainings. Obtaining an account is easy.

- 1. Click the Account Login in the upper right hand corner.
- 2. On the login page click on Create One Here
- 3. Enter your information (note that UTS Training Times is mailed to your primary address—you are encouraged to use your home address, especially if it is difficult to get personal mail at your workplace, e.g. hospital system). UTS does not give any of your training profile information to anyone outside of First Steps. The BCDS and UTS will periodically send you email updates regarding First Steps.
- When all information has been entered click the Update Information.
- Register for your annual training fee.

- 6. Once your payment has been posted, you can take the Training Times assessment, under My Quizzes.
- 7. If you have questions or encounter problems email Janice in the UTS Connect office at: registration@utsprokids.org

Indiana First Steps

UTS Training Times

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Web Address: http://www.utsprokids.org
Email: Training questions training@utsprokids.org
Registration questions: registration@utsprokids.org

Service Coordinator Training Dates for 2011-12**

Service Coordination 102: All service coordinators must enroll and complete SC 102 3- 6 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesdays at ProKids, Inc. Indianapolis from 9-4pm 11/8/11 2/14/12 5/8/12 8/14/12

Service Coordination 103: All service coordinators must complete SC103 6-9 months after employment date. If you are unable to adhere to this timeline, you must request a training waiver. Email your request to training@utsprokids.org.

Tuesdays at ProKids, Inc. Indianapolis from 9-4pm 12/13/11 3/13/12 6/12/12 9/18/12

All Service Coordinators must register online for SC 102 and SC 103 at www.utsprokids.org.

DSP 102 and DSP 103 New Provider Follow Up Orientation**

All newly enrolled providers must complete the DSP series 101, 102 and 103 within the first year of their enrollment. DSP 101 is required for provider enrollment. DSP 102 must be completed three to six months following the provider enrollment date and DSP 103 must be completed six to twelve months following the provider enrollment date. Completion dates for these courses must be documented on the Annual Attestation Statement. The training dates for DSP 102 & 103 are listed below. Usually these trainings are held on the first Tuesday of each month at ProKids Inc. Since there are specific timelines for completion of DSP 102 and DSP103 that allow time for experience in the First Steps System, providers may NOT take both courses on the same day.

DSP 102 Dates	Time	DSP 103 Dates	Time
December 6, 2011	1:00-4:00PM	December 6, 2011	9:00-12:00PM
January 3, 2012	1:00-4:00PM	January 3, 2012	9:00-12:00PM
February 7, 2012	1:00-4:00PM	February 7, 2012	9:00-12:00PM
March 6, 2012	1:00-4:00PM	March 6, 2012	9:00-12:00PM
April 10, 2012	1:00-4:00PM	April 10, 2012	9:00-12:00PM
May 1, 2012	1:00-4:00PM	May 1, 2012	9:00-12:00PM

AEPS 2-DAY Certification Course**

This course provides a 2 day, comprehensive overview of the Assessment, Evaluation and Programming System (AEPS) for Infants and Children. The AEPS is a criterion-referenced developmental assessment tool for children, birth to six years. This course is required for all ED Team members. The 2-day AEPS course may also be used as a First Steps Core Training (FSCT) for your First Steps initial or annual credential. **Cost: \$75**

Nov 3 & 4, 2011 Feb 2 & 3, 2012 May 3 & 4, 2012 Aug 2 & 3, 2012

Additional Opportunities for Credential Points

Providers may utilize trainings (on-site and self-study) and conferences outside of UTS to meet their initial or annual credential points as long as the training is related to provider or service coordinator competencies and it is relevant to infants through age 5. These may include training offered at the SPOE Provider Meetings, provider agency training related to service delivery and First Steps Core Competencies, association conferences (APTA, ASHA, etc.), hospital based conferences or grand rounds, other local, regional and national conferences, and books, videos and online training. You must keep a copy of the agenda or brochure that includes date, speakers, an agenda/content information and the time spent in the sessions you attended or a one page summary of the self-study training in your credential file. More information on credentialing can be found in the recently revised Personnel Guide at

http://www.eikids.com/in/matrix/docs/pdfs/First Steps Personnel GuideRevised 12-2010.pdf

^{**} All training dates after 12/31/11 are pending until the UTS Programmatic Training contract has been issued.

What to Do If You Suspect Your Son/Daughter Might Have an Autism Spectrum Disorder

Contributed by:

Dr. Cathy Pratt, BCBA: Indiana Resource Center for Autism
Dr. Angie Tomlin: Riley Child Development LEND Program
Dr. Noha Minshawi: Christian Sarkine Autism Treatment Center
Dana Renay: Autism Society of Indiana

uring the last decade, there has been much attention on the increasing incidence of autism spectrum disorders (ASD). As a result, parents and professionals may be more likely to recognize developmental differences that could signal autism than in the past. Despite this increased awareness, knowing how to get an accurate diagnosis and what to do after a diagnosis is made, can be confusing and overwhelming. Our goal is to help clarify options, highlight characteristics, and suggest next steps.

Often times, primary care physicians such as family practice doctors and pediatricians are the first professionals that family members will ask for guidance. Doctors can ask parents or guardians specific questions about developmental milestones or behaviors, and may even screen your son or daughter for an autism spectrum diagnosis using a standardized tool. As a result of this process, your child may be given a diagnosis of autism. However, best practice guidelines require a more extensive assessment process that includes a combination of parent interview and direct observation completed by a multi-disciplinary team of professionals who are experienced in working with individuals with autism spectrum disorders.



If you wish to pursue a more thorough medical diagnosis, a list of professionals who can diagnose/assess is available on the website for the Indiana Resource Center for Autism at http://www.iidc.indiana.edu/index.php?pageId=269. This list includes individual providers, such as licensed psychologists, specialty physicians, and diagnostic teams including the Riley Child Development Center LEND Program. These organizations are able to conduct evaluations that may lead to medical diagnoses. When you contact these clinics, ask about waiting lists, whether you need a referral, and the types of payments/insurance they will accept.

While you are waiting for an assessment or diagnosis, DO NOT wait to pursue services. If your child is younger than age three, and you are concerned about behaviors or delays, contact Indiana's Early Intervention System, First Steps at http://www.in.gov/fssa/ddrs/2633.htm or by calling 1-800-441-7837. Your child can receive a professional assessment and if eligible, may receive early intervention services with providers such as a developmental therapist, physical therapist, speech clinician and/or occupational therapist in your home

or other community settings. There is no charge to you for the evaluation although there may be some charge for services. The Autism Resource Network of Indiana (http://www.arnionline.org) can be used to locate First Steps therapists and providers in your area.

If your child is three years of age or older, contact your local special education planning district. They will probably need to evaluate your son/daughter using a team approach that includes a speech clinician, educators, occupational therapist, psychologist, and other professionals.

You will also have the chance to provide input. Even if your child has an autism spectrum disorder diagnosis provided by a physician or psychologist, he or she will still need to be evaluated by the school to show they meet educational eligibility to receive services. In other words, a medical diagnosis does not mean that a child is eligible for educational services.

Autism spectrum disorders are referred to as a 'spectrum' to demonstrate that while individuals share common characteristics, how these characteristics are manifested can be quite different. In other words, no two individuals are the same. The characteristics of autism spectrum disorders present themselves differently in each child. Some children with an autism spectrum disorder show hints of future problems within the first few months of life. In others, symptoms might not appear until 24 months or later. Some children with an ASD seem to develop normally until around 18 to 24 months of age and then they stop gaining new skills, or they lose the skills they once had. For example, a child with an ASD might:

- Not respond to their name by 12 months
- Not point at objects to show interest (example: point at an airplane flying over) by 14 months
- Not play "pretend" games (example: pretend to "feed" a doll) by 18 months
- · Avoid eye contact and wants to be alone
- Have trouble understanding other people's feelings or talking about their own feelings
- Have delayed speech and language skills
- Repeat words or phrases over and over
- · Give unrelated answers to questions
- Get upset by minor changes
- Have obsessive interests (example: lining toys up repeatedly, talking in great depth about only one subject)
- Flap their hands, rock their body, or spin in circles
- Have unusual reactions to the way things sound, smell, taste, look or feel

For more information about characteristics and normal developmental milestones, visit the website for the Centers for Disease Control at http://www.cdc.gov/ncbddd/autism/facts.html.

If your son or daughter is given an autism spectrum disorder diagnosis either by a medical provider or by the school, you will have many questions. There is much information on the web and via the media. Your challenge will be discerning what is useful and what strategies have a proven record. Each child on the autism spectrum will need a different intervention, and the decision about what is right for your child and family is a hard one. There are many services and options in Indiana. Contact one of the following organizations and they can help you navigate the service delivery system, as well as provide support, resources, and referrals within your area.







Indiana Resource Center for Autism at 1-812-855-6508, http://www.iidc.indiana.edu/irca or via email at prattc@indiana.edu

Riley Child Development Center LEND Program at 1-317-944-8167, http://www.child-dev.com/page.cfm?id=25

Autism Society of Indiana at 1-800-609-8449, www.inautism.org or via email at info@inautism.org

Provider Agency Meeting Notes September 23, 2011

State updates:

- Staffing Changes: First Steps says "best wishes" to Jeremy Hawk, who will be joining the State Budget Agency and "Hello" to Leslie Ann Jones, who joined the First Steps team this week.
- The First Steps system received a "Meets Qualifications" from the Office of Special Education Programs (OSEP). "Meets qualifications" is the highest rating that a state may receive. Indicators for success are the provision of timely services, writing IFSPs within 45 days, transition outcomes, services in the natural environment, child find and progress towards child and family outcomes. For complete information on the Annual Performance Report, please visit: http://www.utsprokids.org/firststepsinfo.asp
- Communication is important....When the state has updates or changes to its policies, they will be
 emailed to the Agency contacts. Please distribute the updates to your providers and staff, as appropriate. Information will frequently be posted on the FS web and UTS website (www.utsprokids.org).

Local updates and reminders:

- Agencies are required to participate in the LPCC. If you serve in more than one cluster, please remember that your participation is needed in all of your service areas.
- Monthly, each LPCC is required to send to the state a complete concern log. This log must contain
 any concern that was received by the SPOE or LPCC. In addition, the LPCC will include the following
 issues: progress report timeliness; lack of ability to accept referrals when an Agency is listed as open;
 and complaints from families regarding timely service. Logs are reviewed monthly by the state, to
 identify local and state wide trends, for training and quality purposes.

Federal updates:

Part C regulations have been released. http://www2.ed.gov/policy/speced/reg/idea/part-c/idea-part-c-final-regs.pdf
 While no impact is anticipated, the state office will notify provider Agencies and SPOEs if there are any changes that will impact services in Indiana.

Providers Matrix:

- Matrix pages must be updated for each provider. Please verify that the contact information is up to date and correct. Parents and Service coordinators rely on this information when contacting your providers.
- Check with your local SPOE to determine if they use the availability section of the Matrix page. If they do, please make sure that it is accurate and up to date.
- You are welcome to put a link to your agency's web page in the provider matrix comment section. You may also add information such as accreditation.

Removing a provider:

- When a provider leaves an Agency, submit a request, on Agency letterhead to remove the provider from the agency. You must include within the letter the date in which the last authorization expires. This date will be the actual termination date for the provider, allowing you to continue billing on active authorizations. All removal letters should be submitted directly to the state, with a copy to the SPOE. Providers leaving an agency may not be offered for ongoing services that will extend beyond their departure date. It is the agency's responsibility to submit the removal letter within two (2) business days from the provider's notification.
- <u>Developmental Therapist with Waiver</u> DTs that were approved with a waiver were allowed to make
 the necessary agency changes until 6/30/11. Starting 7/1/11, DTs are held to the enrollment level requirements published in the Personnel Guidelines to enroll or when changing agencies. However, if a
 DT with a waiver is enrolled with an agency that is no longer operating in their approved service area,
 they may request enrollment in a new agency. Concerns, complaints, fees, training, audits, and Corrective Action Plans will be considered when reviewing waiver requests. Waivers are not guaranteed.

Billing:

• The agency is required to maintain the original face to face forms which support the billing/payment of First Steps services. This original documentation must be made available during an audit. The agency should not bill for services prior to review of the original face to face form.

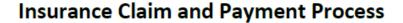
- Please review your quality review procedures to determine that to the best of your ability services are
 occurring as they are listed on the face to face forms. Be prepared to share and discuss these procedures in an audit.
- Review of the ICD-9 and CPT codes for accuracy is critical to revenue recovery. Agencies should
 only be using ICD9 CM codes when billing for therapies. Use of non CM codes will result in a denial
 or lack of acceptance by most insurance companies. (see list of invalid ICD9 codes on page 9)
- Please remember that billing is to occur within 60 days from the date of service. If a correction to a claim is required, corrections should be made within 180 days.

Service Delivery:

- If your Agency is approved in a service area, you are expected to accept referrals in that **entire** service area. Agencies may not limit services within a service area. If your Agency does not have openings, you may voluntarily "close" by notifying the SPOE that you are not accepting referrals at the current time. Once openings are available, you should let the SPOE know that you may once again be offered. If you accept a referral you assume responsibility for meeting the comprehensive needs of the child.
- Once a referral is accepted and the IFSP written, the Agency should initiate scheduling for services with the family. It is expected that the provider will attempt contact within 2 days from the completed referral. Services are to be initiated no later than 30 days from the IFSP meeting. If you are having difficulty contacting the family, please contact the SPOE! It is expected that the provider will hold open the service slot for a minimum of 2 weeks from the notification of referral. Before returning the referral, you must notify the SPOE of the situation and allow the SC two business days to contact the family, notifying them of the situation. If you encounter this situation, please make sure that you are documenting your attempts at contacting the family, as well as notifying the SPOE of the situation.
- If services are not initiated within 30 days from the IFSP meeting, the provider must notify the SC of the cause for delay. Families may request a delay in services...Providers, may not.
- If an Agency needs to "change" providers, please remember that the family should NOT experience a disruption in services. Services should transition smoothly from one provider to another.
- SPOEs/LPCCs are required to report to the State monthly, situations where an Agency turned down a
 referral when they are listed as open, inability of an agency to provide necessary services, as well as
 other complaints and /or concerns.
- If an Agency is unable to accept 3 consecutive referrals, the SPOE has the ability to discontinue referrals to the provider for a period of 30 days. This may also occur if the Agency is unable to meet the needs of the children that they are currently servicing, thus requiring the SPOE to locate a new Agency to provide services.
- Provider Substitution First Steps has long recognized that there are times when a provider may be unavailable due to illness, vacation, personal emergencies or leaving employment. In these short (less than 2 week) planned or un-planned instances, the provider agency may substitute a provider of the same level and discipline, when the family indicates a desire to continue their IFSP service without interruption. (Families have the option to wait for their regular provider to return.) The substitute must provide services as outlined in the IFSP and the plan of care determined by the ongoing provider. The provider agency bills for the substitute under the established authorization. The Service Coordinator should be provided with a courtesy notice of the change in providers. A change in authorization will not occur for this level of substitution. The provider agency is also responsible for insuring that the substitute provider is reimbursed per their employment and/or contract agreement.

When the length of absence is anticipated to exceed 2 weeks, (i.e., maternity or family/medical leave or change in employment) the Provider Agency should contact the family to assist them in choosing a new provider of the same level and discipline. If the provider agency is able to identify a new provider of the same level and discipline, the provider agency may continue to bill on the current authorization through its end date. The Provider Agency must notify the service coordinator of the change in provider. The service coordinator will obtain an authorization for the new provider with the next change page authorization.

(Continued on Page 13)



IFSP Services Authorized

IFSP Service provided



Provider Agency enters claim into PAM

CSC transmits claims to insurance clearing house

Claim accepted or rejected



Claim accepted and sent to insurance company for payment



Insurance pays or denies claim



Claim is paid, EOB payment sent and family is credited cost participation fee for that claim.



Claim is rejected and is not forwarded to insurance company. Family receives no EOB, as insurance never received claim for service. Since there was no insurance payment, the family is charged the cost participation fee for the service. The claim is not resent until provider or family corrects claim information and requests resubmission.



Claim is denied by insurance company, EOB denial is sent to family. The claim is not resubmitted until claim is corrected or family successfully appeals claim and requests resubmission.

Claimed Diagnoses Rejection List

The following TPL claims submitted by CSC on 8/16/2011 were rejected due to the ICD9 code listed on the claim. The rejection reason provided was "Principal diagnosis must be a valid diagnosis code".

A three-digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Section I.b.3., General Coding Guidelines, Level of Detail in Coding.

Coding is the responsibility of the provider and his/her agency. CSC cannot provide codes or change codes after they are entered for billing. Providers/agencies should use the diagnosis look up in PAM to insure that the code with the most specificity is utilized.

Number of Claims rejected	Invalid ICD9 Code	Narrative Description
2000	783.4	Unspecified lack of normal physiological development
1046	784.5	Other speech disturbance
617	315.3	Developmental speech or language disorder
527	765.1	Disorders relating to other preterm infants
438	758	Chromosomal anomalies
188	787.2	Dysphagia
182	765.0	Disorders relating to extreme immaturity of infant
133	741.9	Spina Bifida without mention of hydrocephalus
101	299.0	Autistic disorder
70	749	Cleft palate and cleft lip
64	315	Specific delays in development
63	389	Hearing loss
58	749.2	Cleft palate with cleft lip
57	438.1	Speech and language deficits
56	345.6	Infantile spasms
47	765	Disorders relating to short gestation and unspecified low birth weight
48	741.0	Spina Bifida with hydrocephalus
36	783	Symptoms concerning nutrition metabolism and development
36	345.9	Epilepsy unspecified
34	743.3	Congenital cataract and lens abnormality
32	342.9	Hemiplegia unspecified
32	755.6	Other congenital anomalies of lower limb including pelvic girdle
30	741	Spina Bifida
27	754.4	Congenital genu recurvatum and bowing of long bones of leg
25	299.9	Unspecified pervasive developmental disorder
24	764.0	Light-for-dates infant without mention of fetal malnutrition
19	756	Other congenital musculoskeletal anomalies
19	389.1	Sensorineural hearing loss
19	655.5	Suspected damage to fetus from drugs affecting management of mother
19	749.0	Cleft Palate
18	749.1	Cleft Lip
17	299	Pervasive developmental disorders
17	754.7	Other congenital deformities of feet
16	755	Other congenital anomalies of limbs
16	715.3	Osteoarthrosis localized not specified whether primary or secondary
15	379.5	Nystagmus and other irregular eye movements
15	742.5	Other specified congenital anomalies of spinal cord

In the context of ICD-9-CM coding, the "highest degree of specificity" refers to assigning the most precise ICD-9-CM code that most fully explains the narrative description of the symptom or diagnosis. Concerning level of specificity, ICD-9-CM codes contain either 3, 4, or 5-digits. If a 3-digit code has 4-digit codes which further describe it, then the 3-digit code is not acceptable for claim submission. If a 4-digit code has 5-digit codes which further describe it, then the 4-digit code is not acceptable for claim submission.

Finding The Correct ICD9 Code

It really is not that difficult to locate the most appropriate ICD9 code for billing. There are many free ICD9 search sites on the internet. Additionally many provider associations provide coding updates on their website (e.g., ASHA's coding updates are at http://www.asha.org/practice/reimbursement/coding/newICD9SLP.htm).

While the ICD9 was written for use in 2009, it is updated semi-annually. Providers and their agencies need to be aware of updated codes. The screen shot below (using the website www.icd9data.com) illustrates a search for the code 315.3 (developmental speech or language delay). This code was updated in 2011 and now 315.3 is an invalid code for billing insurance because it does not provide adequate detail. On the website this is indicated by the RED arrows. Providers who may have successfully used this code in the past are now being informed that the code was rejected. A quick search finds that there are now five subclassifications for this code. The provider must choose a valid code (GREEN arrows) > that best fits the child's diagnosis/condition/symptom that the provider treated. All codes for this diagnosis are now five digits.

When providers or their agencies enter claims on PAM, they must know the correct ICD9 code for the claim before entering the claim. Providers are cautioned not to enter codes that are not at the most specific level for the diagnosis, as they will be rejected and never sent to the insurance company for payment. In those cases, parents are required to pay cost participation fees for the services received. Correcting codes in PAM once the provider has been paid by CSC is extremely difficult and time consuming. CSC cannot provide ICD9 codes for child services and they are NOT allowed to change codes once they are entered by the provider/agency. Taking a few minutes to confirm the correct ICD9 code before entering claims, will enhance insurance reimbursement and save families from having to pay out-of-pocket for First Steps services.



315.3	
<u>S</u> earch	

appropriate for the child and service provided.

2011 ICD-9-CM Diagnosis Codes > Mental Disorders 290-319 > Neurotic Disorders, Personality Disorders, And Other Nonpsychotic Mental Disorders 300-316 > Specific delays in development 315-

RED 100 2011 ICD-9-CM Diagnosis Code 315.3

Developmental speech or language disorder

There are 5 ICD-9-CM codes below 315.3 that define this diagnosis in greater detail. Do not use this code on a reimbursement claim.

Newer versions of ICD-9-CM 315.3

2011 ICD-9-CM Diagnosis Code 315.3 Po NOT use 315.3 on a reimbursement claim.

Developmental speech or language disorder GREEN 2011 ICD-9-CM Diagnosis Code 315.31 315.31 - 315.39 are all acceptable codes, select the most

Expressive language disorder

GREEN Diagnosis Code 315.32

Mixed receptive-expressive language disorder

GREEN ED 2011 ICD-9-CM Diagnosis Code 315.34

Speech and language developmental delay due to hearing loss

GREEN Diagnosis Code 315.35

Childhood onset fluency disorder

GREEN 2011 ICD-9-CM Diagnosis Code 315.39

Other developmental speech disorder

- · Speech disorders involving the substitution, omission, distortion, or addition of phonemes.
- Since the TT is printed in black & white, the arrows above have been coded for you. RED = not valid codes and GREEN = valid codes for billing

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Fixing Non-Reimbursable ICD9 Codes



Once a claim has been paid, the provider must contact CSC in order to change the ICD9 code previously used. The provider/provider agency will need to submit a request in writing to the CRO billing department. The request must include the claim number, service date, rendering provider name and the new ICD9 code along with a brief explanation of the request (e.g., "Please change the ICD9 code on the following claim(s):"). The address for submission is:

Central Reimbursement Office c/o CSC PO Box 2507 Greenwood, IN 46142

UNIVERSAL PRECAUTIONS FOR HOME VISITORS

Early intervention providers need to be knowledgeable about infectious diseases that can be transmitted, including those spread through contact with blood and other potentially infectious body fluids. Because of confidentiality laws, individuals and parents, in the case of a minor child are not required to disclose HIV/AIDS, therefore all First Steps providers should be trained in and use universal precautions when providing IFSP services.

Universal precautions are a system of protections created by the Centers for Disease Control (CDC) in an

attempt to prevent the spreading of blood-borne pathogens. Individuals who provide therapy within the home must be cognizant of, and carefully follow, these safety procedures to ensure that they do not become infected with a communicable disease during the course of providing services. By following the CDC guidelines carefully, providers can substantially decrease their risk of contracting a communicable disease.

"Understanding the route of transmission not only tell us how we spread disease, but also directs our efforts in preventing the spread of disease."

Communicable diseases are spread from person-to-person in the following ways:

- 1. Respiratory droplets from the nose or mouth
- 2. Direct contact with infectious material, blood or body fluids
- 3. Fecal-oral route through hands, food, mouthed toys infected with germs from feces
- 4. Blood borne through blood and certain body fluids, primarily Hepatitis B & C and Human Immuno-deficiency Virus (HIV).

HIV/AIDS - The number of children born with HIV infection is decreasing. Each year approximately 1800 children are born with HIV infection. Most of these children were infected by their mothers during pregnancy or at the time of delivery. The CDC has reported a dramatic decrease in pediatric AIDS due to prenatal testing and the use of zidovudine (ZDV or AZT) during pregnancy.

While sharing personal articles contaminated with blood (e.g., toothbrushes and shaving razors) has been implicated in the transmission of HIV/AIDS, it is important to note that HIV/AIDS is not easily transmitted in typical daily activities for adults and children. HIV/AIDS <u>IS NOT</u> transmitted by:

- 1. Casual contact with an infected person
- 2. Holding, hugging or shaking hands with an infected person
- 3. Sharing food, utensils, clothing, bed linens, toys with an infected person
- 4. Kissing on the lips or cheeks
- 5. Coming in contact with perspiration, tears, saliva, vomit, urine or stool of an infected person
- 6. Sharing drinking fountain or restroom
- 7. Mosquito bites

(Continued on page 12)

UNIVERSAL PRECAUTIONS FOR HOME VISITORS (continued)

Hepatitis A, B & C are easily confused because of the similarity of their names. Each of these diseases is caused by a separate and distinct virus. However, they all infect the liver and may show similar symptoms. Hepatitis A is spread through the fecal-oral route and is often referred to as "infectious hepatitis". Travelers to areas of high contamination can get vaccinated against Hepatitis A.

Hepatitis B is spread through the blood borne route. You can be a carrier of Hepatitis B and not have any symptoms of the disease. Everyone should be vaccinated against HBV.

Hepatitis C was first identified in the mid 1970's, but it wasn't until 1992 that a test for Hepatitis C (HCV) became available. Injecting drug abuse accounts for over 60% of HCV, the remainder comes from sexual exposure, hemodialysis and prenatal exposure. Currently, there is no vaccine against HCV.

Understanding the route of transmission not only tell us how we spread disease, but also directs efforts in preventing the spread of disease. The principles of infection control remain constant, whether HIV, HBV, HCV, other infectious agents or even the common cold are the cause for concern. The components of universal precautions include:

- Personal Protective Equipment gloves, gowns, masks, and eye protection. While providers should treat all blood as potentially infectious, there is minimal concern for blood exposure while providing First Steps services. Providers should observe precautions when performing invasive procedures (e.g., tracheal suctioning) and for dressing changes. To prevent the spread of disease from the fecal-oral route, providers should wear gloves when changing/handling soiled diapers, nasal secretions and vomit.
- 2. **Hand Washing** is the most effective defense against the spread of infectious disease, including the common cold and flu. Proper hand washing includes:
 - Soap (liquid is preferred as bar soap can harbor bacteria) and water
 - A vigorous rub for 30 sec.
 - Contact with all surfaces of the hand, fingers, nails and wrist
 - Rinse, letting water drain from wrist to fingers, do not turn off faucet
 - Dry hands with paper towel and use it to turn off faucet
 - Discard paper towel in trash

Antiseptic hand cleansers are effective alternatives if running water is not available, but they should not replace the need for a proper hand washing when a sink is available. To be effective hand sanitizers should be at least 60% alcohol; use 1/2 teaspoon and rub hands for 10-15 seconds.

- 3. Decontamination using appropriate cleaning methods to decontaminate surfaces, objects, etc. Provider should clean shared toys, pens and other objects before and after therapy sessions using a commercial sanitizing spray or an inexpensive bleach solution. The CDC recommends disinfecting dirty surfaces and soiled items, including toys by first washing the items with soap and water and then soaking or spraying the item with a solution of chlorine bleach (made by mixing 1 tablespoon of bleach and 4 cups of water). Once the object is dry it is safe because the chlorine has evaporated.
- 4. Waste disposal all contaminated waste (diapers, band-aids, etc.) should be sealed in a plastic bag before discarding. Regulated waste (saturated with blood and/or body fluids) should be placed in special hazardous waste containers. Any needles and sharps used in the home should be disposed of in puncture resistant, leak proof containers.
- 5. **Maintain health and get vaccinated -** along hand washing, the provider's health and immunity status will have the greatest affect in preventing communicable disease. All providers should maintain up-to-date vaccinations, including Hepatitis B, Tetanus, Pertussis and an annual Flu shot. Caring for oneself through proper diet, exercise and a healthy lifestyle will arm you against common bacterial and viral infections.

For more information on universal precautions, visit Universal Precautions in the Home Health Care Setting at eHow.com http://www.ehow.com/list 6922034 universal-home-health-care-setting.html#ixzz1aPGndQ93.

Provider Agency Meeting (Continued from page 7)

- If the provider agency cannot offer a provider of the same level and discipline, they must notify the service coordinator, who will contact the family to discuss their options for changing/discontinuing the service or choosing a new provider agency that can offer a provider of the same level and discipline. Agencies may use an associate level staff (COTA for OT or PTA for PT) when it is appropriate to do so, and the parent has agreed to the change. In this situation, the Agency may bill on the current specialist authorization, however may only bill at the associate level rate. It is the responsibility of the Agency to determine if the skill level of the associate level staff is sufficient to meet the needs of the child and verify that the necessary CPT codes are allowable under the current authorization. When providing substitute services, the provider is to document on the face to face form that they are serving as the substitute and clearly document their name and discipline.
 - Authorizations: It is the Agency's responsibility to verify the accuracy of provider authorizations.
 Once an authorization/IFSP is signed off on by the parent and physician, it should be entered at
 the SPOE, within 10 business days of the authorization of the service (signature of the parent and
 physician on the IFSP) If an authorization is missing or authorized in error, please follow the SPOE
 procedures
 - Changes to the service plan may occur AFTER the current IFSP has been implemented and shown to be unsuccessful. Requests must include a description of the current strategies being utilized, strategies that were previously attempted, and the perceived barriers to the success of service
 - Recommendations for services or service providers should only be made if they meet the needs of the child. Agencies should not make suggestions for changes to services or disciplines to meet provider availability or scheduling.



Baby Sign Language

Babies can communicate with you before they can talk. Children learn to point, wave goodbye and blow kisses before they speak. They use gestures to communicate while verbal abilities catch up with intellectual abilities. Baby sign language enables children to tell you if they are hungry, thirsty or need a diaper change. Baby sign language research suggests that infants who use sign

language speak sooner and score higher, when tested after second grade. Baby Signing Time encourages signing and speaking together. Children hear the word, see the word, say the word, and model the word with their hands. Caregivers do not need to become fluent in baby signing, even learning a few signs like 'milk', 'more' and 'diaper' can help. Baby Signing Time teaches American Sign Language signs because if you are going to learn signs, you should learn signs for a real language rather than a made up signs. Learning ASL will enable your child to communicate with thousands who are hard of hearing or deaf. ASL signs are natural, easy and fun for babies.

Speech Delays

Sign language will not delay speech. Infants are naturally hardwired to acquire language. Toddlers want to communicate and sign language provides a fun way to for them to express themselves until their verbal abilities catch up with their cognitive abilities. In many cases, sign language accelerates speech for hearing children, including those with autism. Signing Time promotes speech and language through a multi-sensory approach as children see, hear, say and then model the word with their hands. Signing Time is beneficial for speech therapy because it helps children understand that words have meaning and objects have names.

Special Needs Groups

Sign language has given a voice many children with special needs, who otherwise had difficulty communicating. Signing Time helps children of all abilities communicate better and clearer, including those with autism, apraxia, down syndrome, spinal bifida, ADD, ADHD, developmental delays, speech delays and language delays. Signing Time has been instrumental in unlocking the once silent voices of many children who were unable to communicate through speech and unable to express even their simplest thoughts until now.

Rachel Coleman, founder and owner of Signing Time, has seen the benefits of signing with her own special needs child. Rachel's daughter Lucy was born with spinal bifida and cerebral palsy. Doctors worried Lucy would be unable to speak or use sign language to communicate with her deaf sister, Leah. After two years of showing no interest in communication and in spite of her cerebral palsy, Lucy signed her first sign. Now Lucy is fluent in ASL and English! Lucy is the first of many Signing Time miracles. Read more at http://www.signingtime.com/

UTS is exploring the opportunity to bring Rachel to Indianapolis in April 2012!! Stay tuned....



The Flu: A Guide For Parents

FLU INFORMATION

What is the flu?

Influenza (the flu) is an infection of the nose, throat, and lungs caused by influenza viruses. There are many different influenza viruses that are constantly changing. They cause illness, hospital stays and deaths in the United States each year.

The flu can be very dangerous for children. Each year about 20,000 children younger than 5 years old are hospitalized from flu complications, like pneumonia.

How serious is the flu?

Flu illness can vary from mild to severe. While the flu can be serious even in people who are otherwise healthy, it can be especially dangerous for young children and children of any age who have certain long term health conditions, including asthma (even mild or controlled), neurological and neurodevelopmental



U.S. Department of Health and Human Services Centers for Disease Control and Prevention conditions, chronic lung disease, heart disease, blood disorders, endocrine disorders (such as diabetes), kidney, liver, and metabolic disorders, and weakened immune systems due to disease or medication. Children with these conditions and children who are receiving long-term aspirin therapy can have more severe illness from the flu.

How does the flu spread?

Most experts believe that flu viruses spread mainly by droplets made when people with the flu cough, sneeze or talk. These droplets can land in the mouths or noses of people who are nearby. Less often, a person might get the flu by touching something that has flu virus on it and then touching their own mouth, eyes or nose.

What are the symptoms of the flu?

Symptoms of the flu can include fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills, fatigue and sometimes vomiting and diarrhea. Some people with the flu will not have a fever.

How long can a sick person spread the flu to others?

People with the flu may be able to infect others by shedding virus from 1 day before getting sick to 5 to 7 days after. However, children and people with weakened immune systems can shed virus for longer, and might be still contagious past 5 to 7 days of being sick, especially if they still have symptoms.

PROTECT YOUR CHILD

How can I protect my child against the flu?

To protect against the flu, the first and most important thing you can do is to get a flu vaccine for yourself and your child.

- Vaccination is recommended for everyone 6 months and older.
- It's especially important that young children and children with long term health conditions get vaccinated. (See list of conditions under "How Serious is the Flu?")
- Caregivers of children with health conditions or of children younger than 6 months old should get vaccinated.
 (Babies younger than 6 months are too young to be vaccinated themselves.)
- Another way to protect babies is to vaccinate pregnant women because research shows that this gives some protection to the baby both while the woman is pregnant and for a few months after the baby is born.

A new flu vaccine is made each year to protect against the three flu viruses that research indicates are most likely to cause illness during the next flu season. Flu vaccines are made using strict safety and production measures. Over the years, millions of flu vaccines have been given in the United States with a very good safety record.

Is there a medicine to treat the flu?

Antiviral drugs can treat flu illness. They can make people feel better and get better sooner and may prevent serious flu complications, like pneumonia, for example, that can lead to hospitalization and even death. These drugs are different from antibiotics, but they also need to be prescribed by a doctor. They work best when started during the first 2 days of illness. It's very important that antiviral drugs be used early to treat the flu in people who are very sick (for example people who are in the hospital) or people who are at greater risk of having serious flu complications. Other people with flu illness may also benefit from taking antiviral drugs. These drugs can be given to children and pregnant women.

What are some of the other ways I can protect my child against the flu?

In addition to getting vaccinated, take – and encourage your child to take – everyday steps that can help prevent the spread of germs.

This includes:

- Cover coughs and sneezes with a tissue. Throw the tissue in the trash after you use it.
- Stay away from people who are sick.
- Wash hands often with soap and water. If soap and water are not available, use an alcohol-based hand rub.
- Avoid touching your eyes, nose and mouth. Germs spread this way.
- If someone in the household is sick, try to keep the sick person in a separate room from others in the household, if possible.
- Keep surfaces like bedside tables, surfaces in the bathroom, kitchen counters and toys for children clean by wiping them down with a household disinfectant according to directions on the product label.
- Throw tissues and other disposable items used by sick persons in your household in the trash.

These everyday steps are a good way to reduce your chances of getting all sorts of illnesses, but a yearly flu vaccine is always the best way to specifically prevent the flu.



What should I use for hand washing?

Washing hands with soap and water (for as long as it takes to sing the "Happy Birthday" song twice) will help protect against many germs. If soap and water are not available, use an alcohol-based hand rub.

IF YOUR CHILD IS SICK

What can I do if my child gets sick?

Talk to your doctor early if you are worried about your child's illness.

If your child is 5 years and older and does not have other health problems and gets flu-like symptoms, including a fever and/or cough, consult your doctor as needed and make sure your child gets plenty of rest and drinks enough fluids.

If your child is younger than 5 years (and especially younger than 2 years) or of any age with a long term health condition (like asthma, a neurological condition, or diabetes, for example) and develops flu-like symptoms, they are at risk for serious complications from the flu. Ask a doctor if your child should be examined.

What if my child seems very sick?

Even children who have always been healthy before or had the flu before can get very sick from the flu.

Call for emergency care or take your child to a doctor right away if your child of any age has any of the warning or emergency signs below:

- Fast breathing or trouble breathing
- ▶ Bluish or gray skin color
- Not drinking enough fluids (not going to the bathroom or making as much urine as they normally do)
- Severe or persistent vomiting
- Not waking up or not interacting
- Being so irritable that the child does not want to be held
- ► Flu-like symptoms improve but then return with fever and worse cough
- Has other conditions (like heart or lung disease, diabetes, or asthma) and develops flu symptoms, including a fever and/or cough.

Can my child go to school, day care or camp if he or she is sick?

No. Your child should stay home to rest and to avoid giving the flu to other children or caregivers.

When can my child go back to school after having the flu?

Keep your child home from school, day care or camp for at least 24 hours after their fever is gone. (Fever should be gone without the use of a fever-reducing medicine.) A fever is defined as 100°F (37.8°C) or higher.

For more information, visit www.cdc.gov/flu or www.flu.gov or call 800-CDC-INFO

Annual Training Fee - Now Due

Please note that payment of the Annual Training Fee did not change with the implementation of Provider Agencies. All providers must continue to register for and pay the ATF. While training and credentialing are the responsibility of the individual provider, some provider agencies may pay the ATFs for their staff. Providers should insure payment (either personally or through their agency) before the deadline of the November Training Times assessment (January 31, 2012) to insure that they receive their credential points.

All providers (with the exception of those exempted from credentialing) must register and pay their 2012 Annual Training Fee (ATF) online at http://www.utsprokids.org, by January 31, 2012. The ATF remains at \$60 per provider. The ATF covers the cost of the provider's online Training Profile, the quarterly Training Times, and registration for one (1) First Steps Core Training (FSCT) annually. Remember if you are paying by check, money order or purchase order, you **must** print and include a copy of the confirmation with payment. This is necessary to insure that the correct account is credited. Agencies paying for multiple providers must include confirmations for each provider. Payments received without the confirmation page will be returned to the sender.

In 2008, the Bureau of Child Development Services (BCDS), Indiana First Steps issued new guidelines for the Mandatory Annual Provider/Service Coordinator Training. All providers (with the exception of those exempted from credentialing) are required to attend or complete one First Steps Core Training (FSCT) annually. Trainings eligible for FSCT all have **FSCT** in their title. A variety of topics and learning style options, including classroom and distance education are available.

- In 2012, you are required to attend or complete one First Steps Core Training (FSCT) and four Training Times assessments (Winter, Spring, Summer and Fall). The calendar of available FSCTs is posted online. Additional FSCT will be added throughout the training year. Please note that you cannot complete the same course more than one time. Be sure to review your My Trainings tab before registering for this year's FSCT.
- Providers cannot register for their FSCT without first paying the ATF. Once you register for your Annual Training Fee, you will receive an email confirmation within 2 business days. The confirmation will include an ATF number. You must use this number in lieu of payment for your FSCT (there is a place to enter it on the payment page).
- When you get to the payment page you will have 3 choices; 1) Pay with ATF; 2) Pay with credit card or 3) Pay with purchase order or check. Please make sure that if you are using your ATF to register for your FSCT that you enter the current year's ATF number to pay for your course. For example, the 2012 ATF confirmation can only be used for trainings that occur in 2012. Once you click on credit card or purchase order, you will be charged for the training.
- Most trainings designated as FSCT can also be taken as a topical training. You will recognize
 those trainings offered as FSCT, because they will include FSCT immediately before the course
 title. It is important that if you are taking the training as your FSCT that you use the ATF number
 provided in your confirmation email. This number is only good for one FSCT per year. Registration
 for any additional topical trainings offered will be at the posted rate for the training.
- The BCDS has authorized the AEPS 2-Day Certification Course as a FSCT, however the fee for this training is not covered by the ATF. Providers and Intake/Ongoing Service Coordinators who wish to take this course and count it as their FSCT, still must pay the \$75 fee. You may use your ATF to attend another topical training during the year. Please note that the AEPS® 2-Day Certification Course can only be used as a FSCT once and only in the year that it was completed.
- Courses not eligible for FSCT include SC 101, 102 & 103 and DSP 101, 102 & 103. There is a refresher DSP 101 course for "seasoned" Direct Service Providers. This course is clearly marked as a Refresher course and it includes FSCT in its title. Please note that the Refresher course CANNOT be used for you initial credential period.

Please remember to pay your 2012 Annual Training Fee by January 31, 2012 and don't forget to complete your November Training Times assessment before January 31, 2012.

UTS Training Opportunities

Log onto the UTS Training Calendar to check for dates and times (www.utsprokids.org).

FSCT Child Abuse 101: Indicators of Abuse and Neglect

Understand the indicators of child maltreatment, the risk factors for maltreatment, and reporting laws and responsibilities. Prevent Child Abuse Indiana presenters: Sandy Runkle, MSW and Carol Poole, MSW.

FSCT - Hey Kids, Let's Play!

From the authors of Mommy the T.V.'s Off...Now What? This training targets Service Coordinators and Developmental Therapists new to early intervention, highlighting infant and toddler development, atypical development, and activities and strategies in providing First Steps services.

FSCT – Understanding Diversity within Families

Identify individual beliefs and biases related to your own culture. Determine action steps towards developing cultural sensitivity that can be integrated into your work. Recognize cultural differences and report how you value them in relation to families and have an opportunity to talk about the aspects of recognizing the importance of fathers and their roles within the family structure.

FSCT It's Online, but Can I Trust It?

Who do you trust? Find out how to identify authoritative sources while developing a toolkit of go-to resources for education and health information. Christina Wray is from Center for Disability Information and Referral through the Indiana Institute on Disability and Community (IIDC)

Seminar Objectives:

- 1. Identify authoritative sources online.
- 2. Develop a toolkit of free online resources in health and education.
- 3. Learn how to utilize InSPIRE to access scholarly works in your subject area.

FSCT – Literacy into Therapy

All early interventionists play a vital role in the development of the infants and children we service. As providers, we not only affect a child's current development, we also have the ability to shape a child's future academic and social success. Incorporating literacy into therapy goals allows us as providers to meet the developmental needs, abilities and interests of the children we serve. This training session is an interactive look for all disciplines on why and how literacy can be incorporated into oral language, gross and fine motor and social activities.

FSCT Grief- Facilitating Acceptance

This three hour seminar will focus on the stages of grieving, nature of the loss, effects on the family dynamics and facilitating acceptance- a holistic model for grieving while working with families in the Early Intervention system. The seminar will include personal and situational examples of grief. Additionally, support resources will be provided to be shared with families that providers are working with directly.

FSCT Documentation for First Steps Providers

This half-day course will provide an overview of the early intervention record, including the Individual Family Service Plan (IFSP), Face-to-Face form, and the revised provider progress form. Participants will discuss how to requests changes in IFSP services, writing effective outcomes and organizational strategies to insure that documentation meets all required timelines. Basic information on documentation needed for First Steps credentialing and billing will also be presented.

Upcoming Face-to-Face AEPS Courses

November 3 & 4, 2011 and February 2 & 3, 2012 – AEPS 2-Day Certification Course *\$75 fee applies FSCT – AEPS: An Overview

Available Online First Steps Core Trainings

Need a quick course for credentialing, check out these online offerings available 24/7.

FSCT - AEPS: An Overview

FSCT - A Family-Centered Approach to Procedural Safeguards

FSCT - Direct Service Provider Refresher Course

FSCT - Providing El Supports and Services in Everyday Routines, Activities, and Places

FSCT – Understanding and Implementing Positive Transitions for Children and Families in Early Intervention

ADDITIONAL TRAINING OPPORTUNITIES

Understanding Behavior Difficulties in Young Children: Practical Strategies for Early Intervention Providers A workshop with Heike Minnich, PsyD, HSPP, IMH-E® (IV)

December 16, 2011 * 8:30am- 3:30pm * Marten House - Indianapolis

\$75 Registration fee, includes lunch. Register online at www.utsprokids.org



Beyond learning about behavior, temperament, and attachment, this interactive workshop will provide answers to your "real" behavioral challenges. Participants are asked to submit their most difficult behavioral challenges for discussion.



Documentation for First Steps Providers

Do you find paperwork overwhelming? Are you unsure if your documentation measures up? Do you know how to find the most appropriate and valid ICD9 codes? Do you fear a state review of your billing records? Is your credentialing paperwork in order? First Steps providers and provider agencies can get the answers they need at this FSCT half-day workshop.

Thursday * December 15, 2011 * ProKids * Indianapolis

FSCT - EHDI and Audiology in Indiana

2011 Updates and Helping Families Transition to the School Setting Thursday, November 10, 2011 * 12:30 pm - 4:00 pm * ProKids

Current EHDI issues and statistics will be shared with emphasis on the impact of recent changes to the referral process in Indiana. Other topics to be covered include: Transitioning for Success in School - The Audiologist's Role and Partnering With Families through the Transition Process.





SAVE THE DATE! September 28, 2012

Down Syndrome Conference

Wyndham Hotel - Indianapolis

Outdoor Fun for Toddlers - CELLpops and Mini-Posters

The Center for Early Literacy Learning (CELL) has released two new CELLpops, *Outdoor Fun for Toddlers* that can be used by parents or practitioners to provide toddlers with fun and easy ways to bring early literacy learning into everyday outdoor activities. The CELLpops are interactive web versions of CELL mini-posters that can be used to promote children's early literacy learning. They are available at http://www.earlyliteracylearning.org/ta_cell_pop1.php



CELL is funded by the U.S. Department of Education, Office of Special Education Programs Research to Practice Division and is a major initiative of the Center for Evidence-Based Practices at the Orelena Hawks Puckett Institute.

PLUG INTO A PODCASTS FROM ZERO TO THREE

ZERO TO THREE's podcast series, *Little Kids, Big Questions*, addresses some of the most common (and challenging) issues facing parents of babies and toddlers, such as: helping a baby learn to sleep through the night; dealing with a picky eater; and learning to set limits on children's behavior. These questions—and more—are covered in this series of **12 podcasts**, hosted by Ann Pleshette Murphy, a past contributor to ABC's Good Morning America Parenting Segment and author of several parenting books. Each podcast features an interview with an expert that focuses on how to apply the research of early childhood development to your daily interactions with your baby or toddler. Download the podcasts at:

http://www.zerotothree.org/about-us/funded-projects/parenting-resources/podcast/

- 1. Creating Healthy Connections: Nurturing Brain Development From Birth to Three
- 2. Families, Ourselves: How Our History Influences How We Raise Our Children
- 3. Night-Night...or Not: Talking About Babies, Toddlers, and Sleep
- 4. Early Experiences Count: How Emotional Development Unfolds Starting at Birth
- 5. Beyond "Use Your Words!": How Babies Begin to Develop Self-Control in the First Three Years
- 6. Turning On or Tuning Out: The Influence of Media on Young Children's Development
- 7. Across the Generations: The Role of Grandparents in Young Children's Lives
- 8. Feeding the Body and Mind: Nurturing Healthy Eating Habits From the Start
- 9. Daddy, Papi, Papa or Baba: The Influence of Father's on Young Children's Development
- 10. Shh, Shh, It's Okay: Coping With Crying in Babies and Toddlers
- 11. "I Like Me!": Developing Self-Esteem in the Early Years
- 12. Sharing the Care: How Partnering with Your Child's Caregiver Supports Healthy Development

IDEA, Part C Final Rules Published

Final Part C Regulations and a video highlighting major changes is now available.

The Final Part C Regulations governing the Early Intervention Program for Infants and Toddlers with Disabilities were published in the Federal Register on September 28, 2011. These regulations are effective on October 28, 2011.

An html version with targeted links can be accessed at http://federalregister.gov/a/2011-22783

A pdf version can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2011-09-28/pdf/2011-22783.pdf (PDF: 804kb)

A 20 minute video from the Office of Special Education and Rehabilitative Services (OSERS) highlighting major changes to the regulations is also available online at http://www.youtube.com/watch?v=w4dwwRlumSA

REVISED PROGRESS FORMS

Indiana First Steps has completed its revision of the Progress forms. The revised forms and directions for their use are now available on the UTS website for download. Soon they will also be available on the state website. To download the forms from the UTS website, go to www.utsprokids.org, then click on First Steps Information in the right column (http://www.utsprokids.org/firststepsinfo.asp). You will find the forms below the APR information. Separate forms are available for 1, 2, 3 or 4 IFSP outcomes and there is an Additional Outcome form for use when there are more than 4 IFSP outcomes or more than 5 short term goals for any one outcome. A sample of a completed Progress Report has also posted.

- The forms are only available in Adobe PDF. Providers need to download Adobe Reader X at http://get.adobe.com/reader/. Before downloading be sure to review the System Requirements and make sure that your system operating system (Windows or MAC) is up to date. If you experience problems downloading the forms, typing into the form or saving the form, you should contact your provider agency technical support or ADOBE support at http://www.adobe.com/support/. Please do not contact the First Steps office or UTS for ADOBE technical support.
- The state has informed providers that this revised form must be used for all progress reports. The
 only exceptions made were for reports already in development when the form was made available
 October 1st and for those children exiting First Steps in the next month.
- All reports are due the first of the month, as outlined in Appendix A of the directions.
- LPCCs and SPOEs are required to report to the state, providers who fail to submit timely reports
 or reports on the old forms.
- The report must be a collaborative effort of all direct service providers listed on the IFSP. Provider
 agencies must develop mechanisms for providers to collaborate on the report. Meetings, phone
 consultation, email, and other electronic means may be used. The method of collaboration must
 be documented in the progress form.
- Providers must rename the report to save and again with each edit. The preferable name is child last name and date of report. Be sure to use the legal child name as it appears on the IFSP form.
- Providers can tab through each entry field and the form will auto fill the same information required in different sections (e.g., child name, provider name, etc.)
- In the IFSP Team section, you need to add the discipline of all authorized IFSP service in the first column next to EIS. The provider/agency is responsible for insuring that the Service Coordinator and EDT information is entered.

IFSP TEAM INFORMATION:					
Discipline	Provider Name	Phone	E-mail		
Service Coordinator					
ED Team Contact					
EIS					
EIS					
EIS EIS					
EIS					
EIS					

• In the Current IFSP Services section, providers must enter the treating condition ICD9 code. This is the code that should be used for billing. Providers must insure that they are using a valid code at the highest level of specificity.

CURRENT IFSP EARLY INTERVENTION SERVICES:					
EARLY INTERVENTION SERVICE	Start of Service Date for Current Authorization	Treating Condition with ICD9	Frequency (times per week/mo)	Session Length (# minutes)	Authorization Period (start/end dates of auth)

Progress information must be included for each IFSP outcome. List the IFSP outcome and number
as it appears in the child's IFSP. If you are listed in the Transition Outcomes strategies, you should
also include that outcome. In place of a number, you can enter T.

STRATEGIES FOR WORKING TOWARD TRANSITION	WHO IS RESPONSIBLE?	TIMELINE / EXPECTED DATE OF COMPLETION

• The Progress Form Directions will guide you in completing the IFSP Outcome Review section.

IFSP OUTCO	ME	REVIEW:
Outcome #	:	

Long-Term Goal(s):

STG# :			
Date Set:	Set by:	Expected Achievement Date:	Status Code:
Baseline:		•	•
0			
Current Level:			

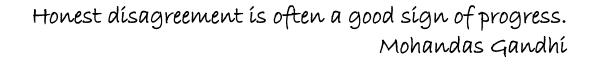
• If you see a child in a child care setting, you should document your sessions with the parent in the Summary of Family/Caregiver Participation. This section should also include Child Care provider participation. Please also include any family information updates that you are aware of (e.g., changes in family size, employment, address, insurance, etc.)

Summary of Family/Caregiver Participation and Family Information Updates:

 Providers must justify the continued need for their service and any change recommendations. All recommendations are pending IFSP team consensus agreement.

<u>SERVICE RECOMMENDATIONS FOR NEXT AUTHORIZATION PERIOD – Pending review and consensus agreement of the IFSP Team:</u>						
EIS	Frequency Session Is this a					

 If you need additional training in the use of the revised progress forms or other required First Steps forms, you should contact your provider agency supervisor or attend the FSCT Documentation for First Steps Providers course.



Healthy Minds:

Nurturing Your Child's Development from 2 to 6 Months

What do we really know about how a young child develops? What can parents do to best support their child's healthy development and growing brain? Some of the answers are in this series of *Healthy Minds* handouts. Each handout is based on findings from a report* from the National Academy of Sciences that examined the research on child and brain development to establish what is known about the early years. The information we offer is age-specific, summarizes key findings from the report and suggests how you might be able to use these key findings to nurture your own child's healthy development.

These handouts are brought to you by ZERO TO THREE, the nation's leading resource on the first 3 years of life, and the American Academy of Pediatrics, dedicated to the health of all children.



Key findings

from the report include:

- Your relationship with your child is the foundation of his or her healthy development.
- Your child's development depends on both the traits he or she was born with (nature), and what he or she experiences (nurture).
- All areas of development (social/emotional/intellectual/language/motor) are linked. Each depends on, and influences, the others.
- What children experience, including how their parents respond to them, shapes their development as they adapt to the world.

How it looks in everyday family life:

Five-month-old Tara loves playing peek-a-boo with her mom and dad. When they stop, she squeals and reaches out her arms to let them know she wants more. So they continue. Soon her parents add another twist to the game as they start to hide behind the pillow for a few seconds before they "reappear" to give her time to anticipate what will happen next.

This simple game is more than just fun. It shows how all areas of Tara's development are linked and how her parents help to encourage her healthy development. Tara's interest in playing with her parents is a sign of her social and emotional development because she has fun with her parents and can see how much they enjoy being with her. This makes her feel loved and secure, and will

help her develop other positive relationships as she grows. Her desire to play this game with mom and dad leads to the development of new **intellectual abilities** as she learns to anticipate what comes next, an important skill for helping her feel more in control of her world. Knowing what to expect will also help her to more easily deal with being separated from you as she learns that people exist even when she can't see them.

Tara's early **language and motor abilities** emerge as she squeals, makes sounds and moves her arms to let her parents know that she does not want them to stop. When they continue, her parents let her know that she is a good communicator, and each time they reappear, she learns that she can trust them to always come back

Relationships are the foundation of a child's healthy development.



American Academy of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN

Charting Your Child's Healthy Development: **2 to 6 months**

The following chart describes many of the things your baby is learning between 2 and 6 months and what you can do to support your child in all areas of her development. As you read, remember that children develop at their own pace and in their own way. Understanding who your child is, what her strengths are and where she needs more support, is essential for promoting her healthy development. If you have questions regarding your child's development, ask your pediatrician.

What's going on:

Babies are very interactive at this age. They use their new language and communication skills as they smile and coo back and forth, and enjoy babbling, starting with "ohs" and "ahs" and progressing to P's, M's, B's and D's. Your baby may babble and then pause, waiting for you to respond. They also love to imitate, which helps them learn new skills. For example, mom sticks out her tongue, baby imitates and mom does it again. This also teaches them about the

What you can do:

- When your baby babbles, both talk and babble back, as if you both understand every word.

 These early conversations will teach her hundreds of words before she can actually speak any of them.

 Engage in back-and-forth interactions with gestures. For example, hold out an interesting
- Engage in back-and-forth interactions with gestures. For example, hold out an interesting object, encourage your baby to reach for it and then signal her to give it back. Keep this going as long as your baby seems to enjoy it.

Questions to ask yourself:

- How does your baby let you know what she wants and how she's feeling?
- How do you and your baby enjoy communicating with each other?
 What do you say or do that gets the biggest reaction from her?

Babies this age love to explore. They learn from looking at, holding and putting their mouths on different objects. At about 3 months, babies begin to reach for things and try to hold them. Make sure all objects are safe. A toy or anything else you give her shouldn't fit entirely in her mouth.

back and forth of conversation.

- Introduce one toy at a time so your baby can focus on, and explore, each one. Good choices include a small rattle with a handle, a rubber ring, a soft doll and a board book with pictures.
- Lay your baby on her back and hold brightly colored toys over her chest within her reach. She'll love reaching up and pulling them close. You will start to see what most interests her.
- What kind of toys or objects does your baby seem most interested in? How do you know?
- How do you and your baby most enjoy playing together? Why?

Babies have greater control over their bodies. By 4 to 6 months, they may be able to roll both ways, become better at reaching and grasping and will begin to sit with assistance. They also begin wanting to explore their food and help feed themselves. Touching and tasting different foods is good for learning and for building self-confidence.

- Place your baby in different positions—on her back, stomach, and sitting with support. Each gives her a different view and a chance to move and explore in different ways.
- Let your baby play with your fingers and explore the bottle or breast during feedings. As she grows, let her handle finger foods and help hold the spoon.
- How does your baby use her body to explore? Which positions does she like the best and least?
- How would you describe your baby's activity level? Does she like/need to move around a lot or is she more laid-back?

*The report, From Neurons to Neighborhoods: The Science of Early Childhood Development, was a 2½-year effort by a group of 17 leading professionals with backgrounds in neuroscience, psychology, child development, economics, education, pediatrics, psychiatry and public policy. They reviewed what was known about the nature of early child development and the influence of early experiences on children's health and well-being. The study was sponsored by a number of federal agencies and private foundations.

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UTS Training Times

UTS Programmatic Training ProKids, Inc. 6923 Hillsdale Ct. Indianapolis, IN 46250



First Steps Autism Survey

Indiana First Steps is requesting input from all service coordinators, EDTs, and ongoing service providers.

Specifically, the state would like input on:

- 1) the comfort level of providers in identifying behaviors that may warrant further evaluation of autism,
- 2) your comfort level in discussing with parents the benefits of exploring a diagnosis or the possibility of a diagnosis of autism,
- 3) your knowledge of resources for parents seeking information on a diagnosis,
- 4) if training on autism screening, referral and/or family resources is needed.

Please take a few minutes to log on and take the 8 question survey about autism. All you need to do is type the web address into your browser http://www.surveymonkey.com/s/5JXS239. You can link directly to the survey from the electronic version of the TT. Your answers are confidential and your input is greatly appreciated!

